

ADLER JR. (L. H.)

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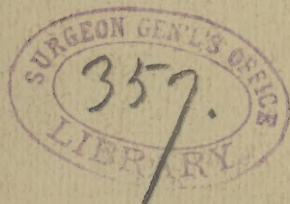
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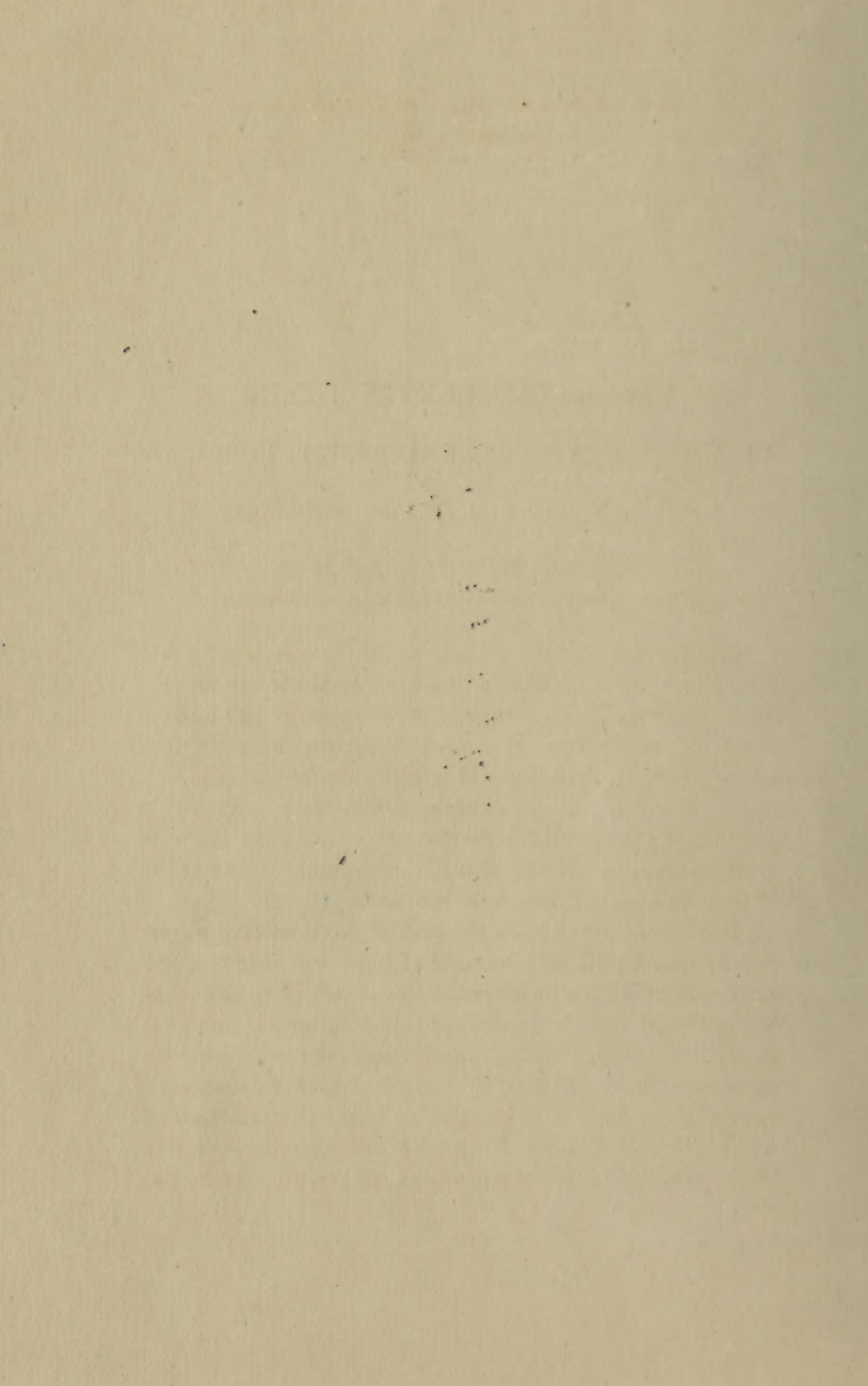
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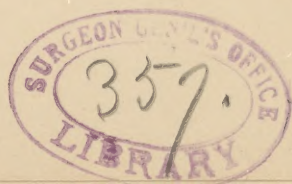
LACERATED CERVIX UTERI
AS TREATED AT THE UNIVERSITY HOSPITAL
BY PROFESSOR WILLIAM GOODELL.

BY LEWIS H. ADLER, JR., M. D.,

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IN Professor Goodell's "Lessons in Gynæcology" mention is made of lacerations of the neck of the womb in the following terms: "The cervix uteri often gives way during labor, far more frequently than it ought—far more frequently, indeed, than it would were nature oftener allowed to take the lead. In these busy days there is, unfortunately, a tendency to urge on labor—more, it is feared, for the sake of the physician than for that of his patient." The truth of this statement, I take it, is undeniable.

Injudicious hurry upon the part of the attending physician is manifested in a number of ways—for instance, the early rupture of the membranes, the resort to instruments before the os uteri is dilatable, the exhibition of ergot, or, finally, the pushing back of the thinned-out cervix over the presenting part. It may be well to state here that, as a matter of course, I do not mean to imply that a laceration seldom, if ever, follows a carefully managed labor, for it often does, as skillful practitioners can testify; but at the



same time I wish to emphasize the fact as laid down by Dr. Goodell that, far more frequently than it should, interference upon the part of the obstetrician is the cause of these cases.

When this lesion exists, what are the symptoms? If it should be a rent which, owing to position or extent, heals by immediate union, the only evidence of its possible existence will be that of bleeding, even when the womb is found to be firmly contracted and the perinæum uninjured. This sign is, of course, only presumptive proof of its presence, and not positively diagnostic.

When the tear is a deep one and fails to heal by primary union, the symptoms are on the third or fourth day—as described by Dr. Goodell—pain in the broad ligament which corresponds to the torn side of the cervix. If the rent is a double one, the inflammation, after subsiding upon one side, may take a fresh start on the other. This pain is often ushered in by a chill. The pulse is rapid and the temperature high. Pain may be absent and the inflammatory symptoms latent, yet the convalescence will be slow—unaccountably so unless firm pressure be made in each iliac fossa, when the woman will flinch.

The diagnosis of these cases to be positive must be made *per vaginam*. This is best done by placing the woman on her side and introducing a duck-bill speculum which is held in place by an assistant. Then, with a uterine tenaculum held in each hand, the fore lip of the cervix is first hooked and then the hind lip, by which means, if a rent exists, the two lips can be drawn forward and will come in contact, with a noticeable fissure between them, running across the neck of the womb.

Before alluding to the mode of treatment in cases of lacerated cervix uteri, I would briefly mention a few of the possible results attending a case left to the healing art of

nature. First, however, I wish to say that Dr. Goodell does not think that every woman who has a tear of the cervix is doomed to a life of invalidism, nor does he think that surgical interference is always called for.

On the other hand, he is decidedly opposed to such views as were expressed in an article in a recent medical journal, by a prominent physician of this State, condemning the use of the knife in all these cases. This gentleman stated that in a very extensive obstetrical practice he had never yet found it necessary to resort to surgical means, and was decidedly opposed to such treatment. With due respect to his opinion and standing in the profession, it must be stated that many women are annually relieved from endless suffering by the method about to be described, who otherwise would have remained invalids for life.

In reference to the results of a case left to nature, unattended by medical or surgical treatment, one of two things happens: the rent heals or else remains ununited; in either event the process of involution is retarded; the inflammation which naturally ensues keeps the womb congested as well as causes an excessive lochial discharge, and these combined circumstances retard convalescence. If the wound unites, the woman's health will in time be re-established; but should no union occur, she will, as a rule, be more or less subject to a sense of weight in the pelvic regions, of backache, of a constant tired feeling, of loss of sexual desire, of pain during coition or of a show following it. The menses will usually be profuse and the intervals between them shorter. Likewise subinvolution of the womb or hypertrophic elongation of the cervix are apt to be developed as secondary lesions. Sterility is not an uncommon result. Miscarriages often follow it, and not infrequently epithelial cancer occurs. With regard to malignant disease, Dr. Goodell, whose experience in these cases has been very large,

says that in the immense majority of cases of cancer of the cervix the trouble starts from a laceration of that portion of the womb.

Now, as to the treatment of these cases, which, for convenience' sake, I shall divide into *palliative* and *operative*.

The palliative measures are best subdivided into *local*, as applied to the womb itself; and *general*, as directed to the patient's physical condition.

Under the head of *general palliative treatment* comes rest, combined with a nutritious but easily digested diet, and supplemented with medicines of a tonic nature. A favorite prescription of Dr. Goodell's is one known in the house as lemonade iron, the formula of which is:

℞ Strychninæ sulph..... gr. ss.;
Tr. ferri chlor..... f 3 iv;
Acid. phosphor. dil..... f 3 vj;
Syr. limonis..... q. s. ad f 3 vj.

M. Dose, f 3 ij, t. d.

In nervous cases he is fond of the following:

℞ Ammonii chloridi..... 3 ij;
Ammonii bromidi..... 3 iv;
Tinct. gentianæ comp.,
Aquæ..... āā f 3 iij.

M. Dose, f 3 ij, t. d.

If anæmia is added to the nervous element of the case, a favorite pill, known as pil. sumbuli comp., is called for:

℞ Ext. sumbuli,
Ferri sulph. exsic..... āā gr. j;
Asafœtidæ..... gr. ij;
Acid. arseniosi..... gr. $\frac{1}{10}$.

M. et ft. pil. No. j. Dose, one pill after meals, to be increased to six pills a day.

The *local palliative treatment* consists, first, in thorough cleanliness of the genitals. The vagina should be washed

out at least twice daily with weak solutions of bichloride of mercury or of carbolic acid. Permanganate of potassium is also a useful drug. Profuse hæmorrhage immediately after the accident is controlled with ice placed in contact with the cervix. Should it fail, vaginal injections of hot water, of tannin, or of alum may be tried, but none of the preparations of iron, since these interfere with immediate union of the parts.

The rent failing to heal by primary union, the treatment should be directed to relieving the local congestion and to protect as far as possible the exposed raw surface of the womb. This is best done by vaginal injections of water as hot as can be borne, by the puncture of the cysts which are formed from the stoppage up of the enlarged Nabothian glands, by painting the eroded surface about once a week with a saturated tincture of iodine, followed before it dries with a weak solution of silver nitrate, which Dr. Goodell says forms not only a protective but also an alterative crust of silver iodide, or by using a solution of a couple of drachms of iodoform in an ounce of collodion, etc.

On account of the cicatricial tissue which the solid stick of lunar caustic causes, Dr. Goodell objects to its use in this class of cases. *Palliative measures* failing to accomplish a cure, we have left but one resort—operation. By the use of the milder treatment we have prepared the patient for the more serious or *operative procedure*, and it is to this treatment that I now wish to direct attention.

The patient is placed in Sims's posture, which allows the abdomen to sag down, and when the duck-bill speculum is introduced the air rushes in, expanding the vagina.

Before beginning the operation the cervix and surrounding parts are cleansed with a 1-to-2,000 solution of bichloride of mercury. The position of the internal os is now ascertained, so as to locate the site for the new cervical

canal. Through this point a piece of strong tared is passed upon a needle, which latter is removed, leaving the cord *in situ* (Fig. 1, A). The ends of this are now tied, and by means of a tenaculum that portion between the two lips of the womb is caught and drawn forward. This doubles the loop into two small ones, each of which steadies one lip of the cervix.

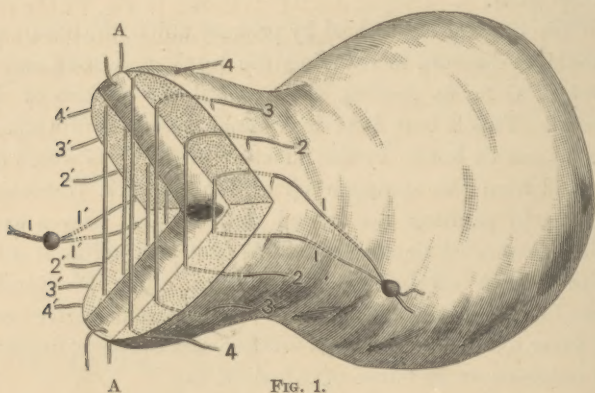


FIG. 1.

The process of denudation is now begun; first, however, two straight, parallel incisions are made upon each lip, on either side of the thread, about a quarter of an inch apart and not very deep, in order to mark out the mucous membrane which is to remain undenuded to serve as the lining for the future cervical canal; after which, to prevent blood from above obscuring what is being done, Dr. Goodell begins at the lower angle of the fissure and denudes up to the two lower incisions. This is repeated above as far as the two upper cuts, care being taken to remove all of the cicatricial tissues. It is usually necessary to remove a wedge-shaped mass of this tissue at each angle of the wound. Often in this operation small Nabothian glands will be seen

filled with a gelatinous material. Whenever it is possible to do so, these should be dissected out.

The next thing is the introduction of the stitches. As those on the lowest side are the most difficult to pass, they are inserted first. The wire used should be as fine as is compatible with safety, No. 31 being Dr. Goodell's favorite size.

The sutures being all passed (as shown in Fig. 1), the next thing to do is to secure them. Before doing this the wound is syringed with some antiseptic solution so as to be rid of all clots and foreign matter that may be present. The shot is then slipped down over a suture and clamped. The same procedure of syringing and of shotting is repeated in placing the remaining sutures. When all are done in this manner, the womb presents the appearance as depicted in

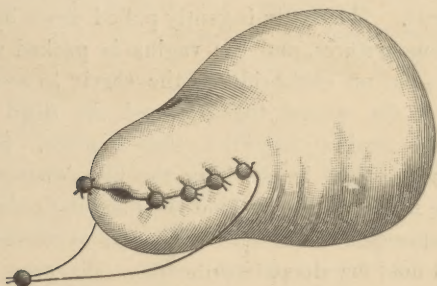


FIG. 2.

Fig. 2. Mention should be made of the fact that, to facilitate the removal of the stitches, Professor Goodell leaves the upper suture on each side several inches longer than the rest, which are cut on a level with the shot. These long sutures have an additional shot clamped over their ends, to prevent injury to the mucous membrane of the vagina. When the time arrives for the removal of the sutures, all

that is necessary is to introduce Dr. Goodell's bivalve speculum, and, by means of traction on these two long wires, the cervix is readily brought well into view. The stitches are then easily removed, first on one side and then on the other. The operation is completed by again syringing out the vagina with a bichloride solution, sprinkling the cervix with iodoform, and packing the vagina loosely with gauze containing the same drug.

In the majority of these cases the surfaces of the wound are so closely and accurately adjusted that not a drop of blood is flowing at the time of the completion of the operation. Sometimes, however, Dr. Goodell has seen a secondary hæmorrhage result. The means previously recommended to stop an excessive flow immediately after the tear has occurred will usually suffice here. Should these fail and superficial stitches not check it, tamponing must be tried as a last resort. The cervix is gently pulled down by means of the two long sutures, and the vagina is packed with three sponges—one on each side of the cervix to compress the surfaces of the wound together, and the third sponge in front of the cervix to keep the others in place. Should this tampon not succeed in checking the hæmorrhage, a suture should be passed deeply behind the bleeding point.

The subsequent treatment of the patient consists in keeping her in bed for at least two weeks. The urine ordinarily should be drawn for forty-eight hours. After the second day the iodoform gauze is removed and the vagina washed out twice daily with a weak antiseptic solution; on the fourth day the bowels are opened, and on the tenth the stitches are removed.

That this operation is successful is shown by the experience of Dr. Goodell in a large number of consecutive cases, mounting up in the hundreds, without a single failure.

A point of importance that should be remembered is to count the number of stitches inserted before the patient leaves the room, for they often become buried, together with the shot, so as not to be readily seen. In illustration of this fact, Dr. Goodell cites a case of a patient of his in the country, upon whom he performed this operation many years ago. In the course of a month or so she came to his office and said that coition was very painful to the husband, who thought there was something in the vagina which ought not to be there. He says an examination revealed, much to his mortification, an overlooked wire suture with sharp points. It had interfered with the marital relation, but it had given the woman no pain or inconvenience.

The proper time for the performance of this operation is about a week after the menstrual flux. If it is performed earlier or later than this, it will be likely either to renew the last period, or to bring on prematurely the next one. Dr. Goodell says, however, that the appearance of the menses while the stitches are in has never in his hands interfered with union.

In conclusion, I wish to express my obligation and thanks to Dr. Herman H. Birney for the figures with which this article is illustrated.

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